



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TX HOSPITAL
3255 W IONEER PKWY
ARLINGTON TX 76013

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

STAR INSURANCE CO

Carrier's Austin Representative Box

Box Number 48

MFDR Received Date

September 17, 2007

MFDR Tracking Number

M4-08-0913-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in the Request for Reconsideration: "HRA has been hired by Northwest Texas Hospital to audit their Workers Compensation claims. We have found in this audit you have not paid the appropriate reimbursement according to the Acute Care Outpatient Hospital Fee Guideline. You will need to reprocess those charges as you did not pay for Implants/Prosthetics/Orthotics. Implants are to be paid at cost plus 10%."

Amount in Dispute: \$4,261.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier, or its agent, submitted a copy of page 1 of the DWC-60; however, no other information was submitted.

Response Submitted by: Gallagher Bassett, 6405 Int. Pkwy, Ste. 2100, Plano, TX 75093

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2006	Outpatient Surgery	\$4,261.50	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on September 17, 2007.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
- M – Reimbursement has been calculated based on a percentage of the charges.
 - M – The recommended payments above reflect a fair, reasonable and consistent methodology or reimbursement pursuant to the criteria set forth in
 - N – Per carrier: Invoice required for implant reimbursement.
 - D – The submitted charge is a duplicate of a previously reviewed charge from the same provider under another provider ID.
 - C - Any network reduction is in accordance with the network reference above. * Focus

Findings

1. The insurance carrier reduced or denied disputed services with reason code C – “Any network reduction is in accordance with the network reference above. * Focus.’ On October 27, 2011 the Division requested a copy of the contract between Northwest Texas Hospital and the network and a copy of the contract between the network and Northwest Texas Hospital. The insurance carrier, or its agent, did not submit a response to the Division’s request. Therefore, the disputed services will be review for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(A), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include “a copy of all medical bill(s)... as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration...” Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).
5. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
6. 28 Texas Administrative Code §133.307(c)(2)(F)(ii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "the requestor’s reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not stated the reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(ii).
7. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
8. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor’s documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of

§133.307(c)(2)(F)(iv).

9. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
- The requestor’s position statement as stated in the Request for Reconsideration asserts that “You will need to reprocess those charges as you did not pay for Implants/Prosthetics/Orthotics. Implants are to be paid at cost plus 10%.”
 - The requestor did not submit implant invoices to support payment.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

September 12, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.